



PATIENT INFORMATION FORM

Date: _____ Social Security #: _____

Patients First Name _____ Middle _____ Last _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Nickname or Preferred Name: _____

Telephone Cell: _____ Home: _____ Work: _____

Marital Status: M S D W Date of Birth: ____ / ____ / ____ Sex: M F

Email Address: _____

Primary Care Physician: _____ Date Last Seen: ____ / ____ / ____

Physician Address: _____

Referral Source – How did you hear about our office? _____

Ethnicity: _____

Employer: _____ Occupation: _____

Preferred Pharmacy and Address: _____

Emergency Contact: _____ Telephone number: _____ Relationship: _____

Please note:

We do not make payment arrangements. All co-pays and deductibles are due at the time of service. It is the patient/guardian's responsibility to understand the individual health insurance coverage.

Blue Ridge Podiatry Associates, PA will make every effort to remind patients of their appointments at least one day in advance. This is done as a *courtesy*. Patients are ultimately responsible for remembering to keep their appointments. Our office requires at least 24 hours notice prior to canceling an appointment. If less than 24 hours notice is given (this includes appointments missed without any notice or appointments canceled on the same day as they are made), our office reserves the right to charge a cancellation or no-show fee to the patient's account.

By signing below I affirm that I have had read and understood BRPA's privacy policy.

Patient (or Guardian) Signature: _____ Date: _____



FINANCIAL POLICY

Thank you for choosing our practice! Establishing a financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunications or concerns regarding financial matters to focus our energies on providing excellent healthcare services to our patients. Insurance plans have different benefits for you as well as different financial obligations. It is ultimately your responsibility to check with your insurance company to determine the covered benefits. We are out of network with all plans except Aetna and Blue Cross & Blue Shield. We only file insurance for BCBS and Aetna plans.

The following are our policies related to financial responsibility:

*We are happy to accommodate these methods of payment: cash, check or credit card. If choosing a credit card, there is a convenience fee of 3.5 % . We can process all major credit cards.

*Payment is required at the time service is rendered. This includes co-pays, deductibles and co- insurance as well as payment for any non-covered or other retail products.

*Please present your insurance card at your initial visit and any time you change insurance carrier/plans, along with photo identification.

*You may be charged a "no show" fee of \$35.00 for any appointments missed, canceled or rescheduled without at least 24-hour notice.

*Balances on your account must be paid in full within 30 days.

*Accounts may be turned over to a collection agency for any balances past due 60 days or more.

*A service charge of \$35.00 will be assessed for returned checks, refiling of insurance due to incomplete or incorrect information given at the time of the appointment or for accounts turned over to collection agencies.

*A fee of \$35.00 will be assessed for the completion of any disability, Family Medical Leave Act (FMLA) attending physician statements (APS) or any other miscellaneous forms.

*Interest in the amounts of 1.5 % (18% annually) may be added to any balances older than 60 days.

*In the case of services provided to patients under the age of 18, the parent, guardian or legal representative who initiates the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment

*A fee of \$10.00 will be charged for any prescription refills.

I hereby authorize Blue Ridge Podiatry Associates, PA ("BRPA") to file all medical claims with my insurances. I hereby authorize payment of insurance benefits to be made to BRPA. I further understand that if my insurance denies any or all medical services as "non-covered", "coverage terminated", "pre-existing" or "non-covered member", I will be responsible for full payment within 30 days of said denial(s). I understand that BRFC will not file any claims for non-covered or over the counter items.

I understand I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all expenses incurred with collection if I default on any unpaid balance.

I fully understand the above policies and agree to be financially responsible for all charges incurred resulting from medical service rendered.

Patient/Guardian Signature

Date



Comprehensive Patient Medical History

Patient Name: _____ Date of Birth: ___/___/___

Shoe size: _____ Height: _____ Weight: _____ Age: _____

Chief Complaint: _____

Have you ever been treated for:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Corns/calluses | <input type="checkbox"/> warts | <input type="checkbox"/> athlete's foot | <input type="checkbox"/> leg/foot ulcers |
| <input type="checkbox"/> broken foot bones | <input type="checkbox"/> lower back pain | <input type="checkbox"/> bunions | <input type="checkbox"/> arch pain |
| <input type="checkbox"/> hammer/mallet toes | <input type="checkbox"/> fungal nails | <input type="checkbox"/> knee pain | <input type="checkbox"/> flat feet |
| <input type="checkbox"/> cramps in legs/feet | <input type="checkbox"/> heel pain | <input type="checkbox"/> childhood foot problems | <input type="checkbox"/> rash |
| <input type="checkbox"/> neuroma | <input type="checkbox"/> broken ankle | <input type="checkbox"/> toe walking | <input type="checkbox"/> in-toeing |
| <input type="checkbox"/> ingrown toenails | <input type="checkbox"/> foot numbness | <input type="checkbox"/> ankle sprain | <input type="checkbox"/> high arch feet |
| <input type="checkbox"/> gait (walking) problems | | | |

Did you previously or do you now wear:

- shoe inserts - still using them? _____ Do or did they help? _____
- orthotics - still using them? _____ Do or did they help? _____ Orthotics were obtained through _____

Are your first steps out of bed painful? Y Nthen subsides? Y N

Do you get leg cramps...during the day? Y Nat night? Y N

Percent of waking hours spent on your feet? _____%

List the sports or type of dance you are active in: _____

Does foot pain limit your activities? Y N Do you have difficulty walking? Y N

Any pain in calves or buttocks when walking? Y N Is the pain relieved by stopping & standing still? Y N

Do you have or have been treated for:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> A heart condition | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Eyes: Glaucoma/Mac Deg | <input type="checkbox"/> Keloid/Thick Scar |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Hearing/ear disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Dark urine | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Chronic light stool | <input type="checkbox"/> Unexplained weight loss | |
| <input type="checkbox"/> Other: _____ | | | |

Do you have vascular grafts? Y N Do you have joint implants? Y N

Do you have replacement heart valves? Y N Are you now under active chemotherapy? Y N

Have you had any other serious illness? (list below) Y N Have you had any surgery? (list below) Y N

Have you ever been hospitalized or been under medical care over 24 hours? (list below) Y N

Illness/surgery: _____	Date: _____	Complications: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List relationship to you of family members who have had:

Diabetes _____ Foot problems _____ Cancer _____
Arthritis _____ Stroke _____ Heart Attack _____
High Blood Pressure _____ Birth Defects _____

Are you pregnant now? Y N # of childbirths _____

Are you slow to heal after cuts? Y N Any abnormal bruising, bleeding, scarring? Y N

Do you smoke now? Y N Packs/day _____ Years _____

Did you ever smoke? Y N Packs/day _____ Years _____

If you quit, when did you do so? _____

Alcoholic beverages? None Rarely Moderately Daily Quit

Recreational drugs? None Rarely Moderately Daily Quit Type: _____

Please mark if you take vitamins or supplements that contain:

___garlic ___gingko biloba ___echinacea ___ginseng ___St Johns wort

List other supplements you take:

List any medications, including insulin you currently taking below along with dosage and frequency:

Allergies: Is there a history of skin reaction or other outward reaction or sickness following and injection, oral or topical administration of:

		If yes, what happens?
Latex, Adhesive tape	Y N	_____
Penicillin	Y N	_____
Other antibiotics	Y N	_____
Empirin, Tylenol	Y N	_____
Aspirin, Advil, Aleve	Y N	_____
Celebrex	Y N	_____
Other pain remedies	Y N	_____
Morphine	Y N	_____
Codeine	Y N	_____
Demerol	Y N	_____
Other narcotics	Y N	_____
Novacaine	Y N	_____
Other anesthetics	Y N	_____
Sulfa Drugs	Y N	_____
Shrimp, Iodine, Merthiolate	Y N	_____
Others:		_____

Is there anything else that you want to tell the doctor?

